

# VENEREAL DISEASES IN THE WEST AFRICAN COLONIES\*

BY

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## Incidence

This cannot be computed readily, as it varies so greatly in different areas. For example, gonorrhoea is exceedingly common in the coastal region, especially in the cities such as Lagos and Accra, but in the rural areas, it is much less common, though in the arid northern territories, especially in such areas as Kano, its incidence is relatively high. Trade routes, both the old caravan routes and the modern motor roads, have a great influence on the spread of both syphilis and gonorrhoea. There is a tendency to say that nobody knows (and nobody greatly cares) how much gonorrhoea there is in West Africa. This is not fair, but it is freely admitted that gonorrhoea is a formidable medical problem.

The incidence of the complications of gonorrhoea is very high, and severe effects of the disease, such as are seldom seen in Great Britain, are very common and fill the hospitals. Urethral stricture and its late genito-urinary effects are frequent surgical problems. Gonococcal arthritis is also a common cause for hospital admission. Ophthalmia, either in the child or adult is rare—a surprising finding after our experience in Egypt.

## Syphilis and Yaws

It is very difficult, if not impossible, to differentiate between many of the late lesions which may be due to yaws or syphilis, though the patterns of the early lesions of these diseases are clear and distinct. It is commonly said that syphilis is a disease of the cities and yaws of the tribal areas. Much has been done by mass-treatment campaigns to reduce the incidence of yaws, but relapse is common, and some of the more remote areas still have minor epidemic outbreaks. The classification of the protean manifestations of these two diseases under the title of "treponematoses" has much to commend it; there is still much to be done in elucidating

this problem, which is not only of considerable scientific interest, but also of first-rate economic importance.

In the ports and cities, syphilis is seen in much the same clinical pattern as in Britain. In the humid areas where yaws is epidemic, the lesions of treponematoses tend to fall into the common pattern of a framboesiform eruption in the early phase, and hyperkeratosis or bone and joint lesions in the late phase. But there are very many instances where it is quite impossible to differentiate between the two diseases, and some cases present "mixed" yaws and syphilitic types of eruptions.

Congenital syphilis of the type seen in Europe is practically never observed, and interstitial keratitis and Hutchinson's teeth are extremely rare. Many infants have an enlarged spleen and liver, and possibly a skin eruption, but some doctors think that all congenital syphilitic children die in early infancy. Periostitis is common in children, and may assume the proliferative pattern with which we are familiar, leading to thickened and dense bone, with curvature of the tibia when that bone is affected. Another common finding is wide-spread osteoporosis of the bones, and this is often ascribed to yaws.

Many children suffer simultaneously from treponematoses, malnutrition, malaria, and anaemia associated with hookworm infestation.

In the cities, where syphilis has become a common disease of adults, there has been an increase in the late lesions of the heart and great vessels, and also of the central nervous system. This is particularly noticeable in men employed on the unloading of ships or similar strenuous work. In this class, sudden death from syphilitic aneurysm of the aorta is not uncommon. *Tabes dorsalis* is rare, and general paralysis of the insane occurs only occasionally.

*Granuloma inguinale* and *granuloma venereum* occur but are not common, whereas *chancroid* is quite frequent.

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### Drug-Resistant Types of Disease

All types of venereal infections appear to respond fairly well to the usual remedies, though sulphonamide-resistant gonorrhoea is universal, and it is even suggested that penicillin-resistant strains gonococcus are now being found. As a rule, the true explanation is that the full dose of the drug has not been given; for a dishonest orderly has a ready market for any penicillin he can obtain by giving short measure in the clinic.

### Social and Educational Factors

The average African has no shame about venereal disease; he is very indifferent to its manifestations, and only seeks medical aid when he has pain, or when his sexual activities are affected. Loss of potency and infertility are, to the African, the most serious effects. In the cities, the African has lost his tribal habits and discipline, he is sexually promiscuous and a libertine. The town dwellers have abandoned many of their own marriage and sex customs, and tend to ape the Europeans. The most ready approach to the women is through the ante-natal and child welfare clinics. Many women, possible cases of late venereal disease, come under medical observation after several years of infertile marriage or the loss of several children. Both sexes regard a childless marriage as a disgrace, and children are given every care often to the point of stupid indulgence.

Many Africans have a love of injections and touching faith in their efficiency. This is partly a tribute to the white man's "magic" and the more pain suffered, the greater is the power attributed to the medicine. It is partly a relic of the bad days of "injectioneering", for the African remembers how a single dose of an arsenical banished all his malaise, pains, and skin lesions. He still finds a dose of an arsenical drug ("N.A.B.") a powerful tonic and aphrodisiac. It will be obvious that it is difficult to persuade the African to attend for treatment or observation after the symptoms and obvious signs of disease have gone.

Many of the more enlightened leaders of the people are aware of the dangers to the health, fertility, and vigour of their tribe which may follow the weakening of the tribal customs, and the introduction of V.D. into the tribal area. This occurs readily through the young men leaving their homes to work in the mines or other industries. While they are away from home they find it easy to consort with prostitutes, and so become infected. In some industries the V.D. patients are well treated, but in many instances, only symptomatic treatment is received. The young man may also be infected

on his return journey from the city or the mines to his tribal area. The speed of travel, usually by motor truck, allows him to reach home either during the incubation period, or before either diagnosis or treatment is practicable. There seems to be a real necessity here for education, and for some form of sanitary control on the main routes between the coast and the interior.

I was informed that one enlightened Sheik had requested that all the prostitutes in his area should be cured. He then proposed to give them in marriage to certain young men who would be charged with ensuring their future chastity. In this way the Sheik hoped to prevent the further spread of V.D. in his tribe; we trust he was successful! Primitive conditions of life and apparently backward social customs are hardly ever to be blamed for the spread of infection.

Some tribes in the north of the Gold Coast wear only a scanty girdle with a small bunch of leaves over the pubis, and a somewhat larger bunch over the buttocks; but these people are very strict in the observance of marriage customs and V.D. is virtually unknown amongst them.

### Problems of Diagnosis

There is a need for a simple serological test with a high degree of reliability which can be performed under "bush" conditions. A great part of African medicine is done in places remote from any form of laboratory. An African technician can be trained to do many tests quite satisfactorily, but he requires constant supervision. The European doctor does not have time to do more than the most simple and rapid tests; the equipment and materials used must be cheap, durable, and capable of withstanding heat and humidity for long periods. Some pathologists expressed great doubt regarding the reliability of the tests in common use, especially the Ide test, though any test is likely to prove unreliable if skilled technicians and trustworthy batches of antigens are not available.

### Therapeutic Problems

There may be great developments in African venereology if the experiments now being conducted by WHO demonstrate the practicability of mass treatment for treponematosis. If the scientific basis of this work is sound then the problem becomes simply one of administration and finance. I am of the opinion, however, that the intensive treatment campaign must be supplemented by prolonged observation and permanent treatment facilities, otherwise the failures and missed cases will quickly re-infect many others, and cause a return to something resembling the

present situation. The West African countries offer a marvellous trial ground for various systems of treatment, and new remedies. The systems advocated however must be simple and cheap ; it would be a great advantage if the drug administration could be completed in a short time. At present I advocate penicillin supplemented by a large depot dose of an insoluble bismuth preparation. Unhappily the colonies have neither the money to finance such schemes nor the staff to administer and implement them, except perhaps on a small pilot scale.

To sum up, it is to be emphasized that the incidence of V.D. is very high, and that treatment facilities

are very meagre, and at present do no more than give temporary relief of symptoms. The real problem is to devise a scheme of treatment which is cheap and easy to administer, then to find the money for drugs and equipment, and then to recruit and train staff for the work.

The problem is ecological as well as medical, for a successful campaign would probably increase the numbers, vitality, and length of survival of the peoples concerned, so that more food, houses, and employment would be necessary for their maintenance. V.D. in West Africa presents a wonderful opportunity to medicine, and a great challenge to our administration.